Self-harm in the criminal justice system: a public health opportunity

Self-harm is a global public health problem associated with increased morbidity, suicide risk, and premature mortality.[1] The behaviour is more prevalent in marginalised groups, including people in prison. The burden of self-harm and suicide in prison is considerable; a study[2] from the UK estimated that the annual prevalence of self-harm in prisons was 5–6% in men and 20–24% in women. With the global imprisonment rate increasing annually,[3] the extent to which the burden of self-harm is concentrated in prisons is also likely to be increasing.

Growing evidence has shown that the incidence of suicide both in prison[4] and after release[5] is markedly higher than in the general population. However, until recently there has been little research examining the epidemiology of self-harm after release from prison. Our study of 1325 adults released from prisons in Queensland, Australia, documented high rates of ambulance attendance[6] and emergency department presentation[7] for self-harm following release. Factors associated with these emergency health-care contacts included identifying as Indigenous, previous emergency health-care contact for self-harm, history of a mental disorder, and being identified by prison staff as being at risk of self-harm.

Imprisonment provides a rare opportunity to identify—and initiate care for—vulnerable people who might be at risk of self-harm. However, in many countries, those at risk come to the attention of prison staff mainly through reception screening, during which they are asked to disclose any history or thoughts of self-harm. This is suboptimal because, first, many people experience acute distress at prison reception and accurately identifying those at increased risk of self-harm can therefore be difficult and, second, prisoners might be reluctant to disclose a history of self-harm because of concerns about being subjected to seclusion or other restrictive practices. Relying exclusively on self-report in custodial settings could substantially underascertain the true prevalence of self-harm history.[8]

Routine use of linked administrative data in prison settings can substantially improve the identification of people who are at risk of self-harm.[8] Adults in prison who disclosed a history of self-harm and had a previous health-care contact resulting from self-harm (ie, the true positive group) were six times more likely to self-harm after release from prison than were those who did not disclose and had no recorded episodes. Furthermore, participants who had a medically verified history of self-harm but did not disclose it (ie, the false negative group) were four times as likely to self-harm. These individuals—who would likely have been missed by routine reception screening—accounted for a fifth of those who self-harmed after release from prison and a quarter of all self-harm events during follow-up, highlighting the crucial role of linked administrative data in identifying and providing information about those at increased risk. Importantly, the rates of self-harm after release from prison did not differ between the true positive and false negative groups, indicating that although the false negative group would likely have been missed by routine screening procedures, these two groups were at a similarly increased risk of self-harm. For individuals presenting to the emergency department after self-harm, the benefits of appropriate mental health assessment and active follow-up are clear.[9] However, despite international guidelines recommending such an assessment for every person presenting to an emergency department for self-harm, just 29% of study participants received such an assessment.[7] The stigma associated with self-harm is a well-recognised barrier to help-seeking in the emergency department,[10] and is likely to be compounded for people recently released from prison. Further research is needed to understand the barriers to engagement with mental health services in this marginalised population.

WHO argues that health care in prisons should be delivered by ministries of health rather than ministries of justice.[11] This model of prison health-care governance has been adopted in the UK and some other countries.[12] A rapid review found that transfer of prison health care in the UK from the Ministry of Justice to the National Health Service had some positive effects on mental health-care provision, continuity of care, and data sharing,[12] all factors likely to assist in preventing self-harm. However, the specific impact of prison health-

care governance on self-harm after release from prison has never been examined empirically, and should be a priority for future research.

Another potential avenue to reduce self-harm in people who experience imprisonment is to increase investment in recruiting and training prison staff—both health and custodial—to identify those at risk. This is a considerable challenge; data from a recent meta-analysis showed low positive predictive values (26%) for risk scales of self-harm.[13] Ideally, identification of those at increased risk would involve prison health staff routinely accessing relevant community health records and conducting needs-based assessments, especially near the time of release. In circumstances where this is not feasible, more efficient information sharing systems between community health care and prisons should be developed. Once people with a history of self-harm have been identified, individually tailored care pathways between prison and community-based primary and secondary health-care services should be clearly defined, complemented by meaningful investment in evidence-based transitional support.

People with a history of imprisonment are distinguished by complex health-related needs and health risk behaviours, including self-harm. Improving their health outcomes is important for reducing health inequalities, with likely benefits for wider public health. Effective responses are needed to address the mental health needs of this population, including addressing the high rates of self-harm after release from prison. Such approaches could contribute to improved outcomes and financial benefits not only for the justice system, but for the broader health system as well. Economic evaluation of these reforms will be essential to support scalability and sustainability.

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